NEW PATIENT

QUESTIONNAIRE AND HISTORY

Today's Date: _____

Name: _____ Date of Birth: _____

Address: _____

City:_____ State:_____ Zip:_____

Home: _____ Cell: _____ Work: _____

Preferred contact number ☐Home ☐Cell ☐ Work
May we send messages via text regarding appointments to your cell? ☐Yes ☐ No

Email: _____
May we contact you via email? ☐Yes ☐ No

Emergency Contact: _____ Relation: _____

Phone: _____

Primary care physician: _____ Phone: _____

Preferred Pharmacy: _____ Phone: _____

Marital Status: ☐Single ☐ Married ☐Divorced ☐ Widowed ☐Living with partner

In the event we cannot contact you by the means you have provided above, we would like to know if we have permission to speak to your spouse or significant other about your treatment. By giving the information below, you are giving us permission to speak with your spouse of significant other about your treatment.

Name: _____ Relation: _____ Phone: _____

Insurance Company: _____ ID: _____Group #: _____

Primary Insured Name: _____ Date of Birth:_____

Address if different: _____

City: _____ State: _____ Zip: _____

Employer: _____ Job title: _____

Address if different: _____

City: _____ State: _____ Zip: _____

Employer Phone: _____ Subscriber's relationship to insured: _____

Medical History:

Height: _____ Weight: _____

Do you have any allergies to medications? ☐Yes ☐ No

If yes, please list your allergies **and your reaction** to them: _____

_____

What medical problems do you have?

☐ Anxiety
☐ Arrhythmia
☐ Arthritis
☐ Asthma
☐ Blood clot/DVT/pulmonary embolism
☐ Cancer
Type: _____
Remission Date: _____
☐ Chronic pain
☐ Depression
☐ Diabetes
☐ Heart Attack
☐ Heart disease
☐ High blood pressure
☐ High cholesterol
☐ HIV/AIDS
☐ Hyperthyroid
☐ Hypothyroid
☐ Liver Disease
☐ Lupus/Autoimmune Disease
☐ Migraines
☐ Seasonal Allergies
☐ Stroke

Other:

_____

_____

What medications and supplements do you take?

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Surgical History:

☐ Adenoids
☐ Appendix
☐ Breast augmentation
☐ Cardiac stents
☐ Cataracts
☐ Coronary artery bypass
☐ C-section
☐ Gallbladder
☐ Hernia repair
☐ Hysterectomy
☐ Lithotripsy
☐ Mastectomy
☐ Tonsils
☐ Wisdom teeth

Other:

_____

_____

Social History:

Please check all that apply:

TOBACCO: ☐ Never smoker ☐ Former smoker ☐ occasional/social smoker
☐ Smokes cigarettes ☐ Oral tobacco ☐ E-cig/Vape
#_____ packs/can per ☐ day ☐week

ALCOHOL: ☐ Does not drink alcohol
☐ Drinks alcohol #_____ ☐ beer ☐wine ☐liquor ☐daily ☐weekly ☐ socially

RECREATIONAL DRUGS: ☐ None ☐marijuana ☐cocaine ☐methamphetamines
☐ prescription drugs ☐_____

CAFFEINE(tea/coffee/soda): ☐ none ☐ rarely #_____ cups per day

Family History:

Please list known **medical problems** of family members.

Mother: _____

Maternal Grandmother: _____

Maternal Grandfather: _____

Maternal Aunts/Uncles: _____

Father: _____

Paternal Grandmother: _____

Paternal Grandfather: _____

Paternal Aunts/Uncles: _____

Siblings: _____

Children: _____

Lifestyle:

Occupation: _____ ☐ Full time ☐ Part time ☐ PRN

Do you exercise? ☐ Yes ☐ No What type of exercises?_____

How often? _____ days per week

Please list any diet restrictions you follow? (e.g. carbs, dairy, keto, diabetic, low salt, etc.) ☐ None

_____

Please list any prior accidents with dates? (car crash, fall, broken bones, etc.)

_____

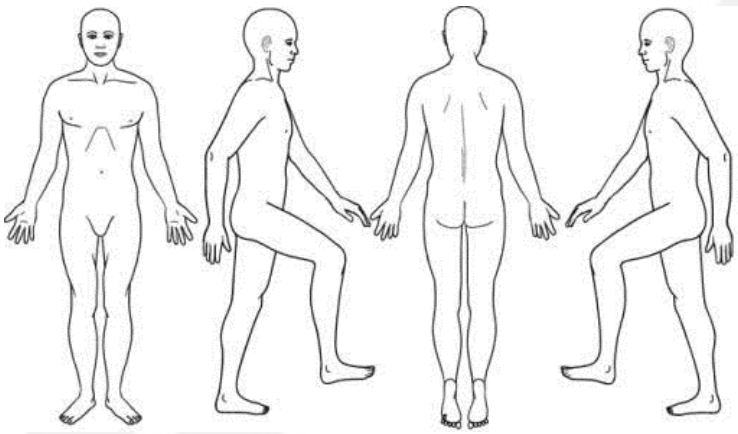
_____

Briefly describe your main problem: _____

_____

_____

Indicate with an X on the pictures below, the area(s) of your pain.



Was there an injury that caused your pain? _____

_____

What does your pain feel like?

☐ Aching ☐ Burning ☐ Cramping ☐ Deep ☐ Diffuse ☐ Dull ☐ Heavy

☐ Intolerable ☐ Numbness ☐ Pulling ☐ Sharp ☐ Shock-like ☐ Soreness ☐ Stabbing

☐ Stiffness ☐ Throbbing ☐ Spasming ☐ Tightness ☐ Tingling ☐ Shooting ☐ Pressure

How often does your pain occur?

☐ Constant ☐ Frequent ☐ Intermittent ☐ Occasional ☐ Resolved

Rate your pain: 0 1 2 3 4 5 6 7 8 9 10

What makes your pain worse?

☐ bending ☐ childcare ☐ driving ☐ getting up ☐ household chores ☐ reaching

☐sitting ☐ sleeping ☐ standing ☐ turning/twisting ☐ walking ☐ work ☐ _____

Circle therapies that relieve your pain. Put an X on therapies that have not worked.

chiropractic adjustment	exercise	Rest	Ice
Heat	Massage	Movement	Stretching
prescription medication	physical therapy	TENS Unit	over the counter medications

Are you having any numbness? ☐ No ☐ Yes **Where?** _____

Are you having any weakness? ☐ No ☐ Yes **Where?** _____

Are you currently on hormone replacement therapy?

☐ No ☐ Yes, What kind?_____

Please choose the options that best describes you:

☐ I am sexually active
☐ I want to be sexually active
☐ I do not want to be sexually active
☐ I have completed my family
☐ I have NOT completed my family

Please rate the following symptoms.

SYMPTOM	Never	Mild	Moderate	Severe
Sweating (night sweats or increased episodes of sweating)				
Sleep difficulty (trouble falling asleep, sleeping through the night or waking up early)				
Depressive mood (feeling down, sad, on the verge of tears, lack of drive)				
Anxiety (inner restlessness, feeling panicky, feeling nervous, inner tension)				
Irritability (mood swings, feeling aggressive, angers easily)				
Physical exhaustion (general decrease in muscle strength or endurance, decrease in work performance, fatigue, lack of energy, stamina or motivation)				
Joint and muscular symptoms (joint pain or swelling, muscle weakness, poor recovery after exercise)				
Bladder problems (difficulty urinating, increased need to urinate, incontinence)				
Brain fog (Difficulties with memory, problems with thinking, concentrating or reasoning, difficulty learning new things, difficulty thinking of the right words)				
Increase in frequency or intensity of headaches or migraines				
Hair loss, thinning, or change in texture of hair				
Feeling cold all the time or have cold hands/feet				
Dry or wrinkled skin				
Weight gain or difficulty losing weight despite diet and exercise				
Sexual problems (change in sexual desire, sexual activity and/or orgasm and satisfaction)				

For FEMALES only:

Hot flashes				
Vaginal symptoms (dryness or burning in vagina, difficulty with sexual intercourse)				

For MALES only:

Urine difficulty (weak stream, non-continuous stream)				
Erectile changes (less strong erections, loss of morning erections)				
Infrequent or absent ejaculations.				

For FEMALES:

Are you currently pregnant? ☐ Yes ☐ No

Are you currently nursing? ☐ Yes ☐ No

What forms of birth control are you currently using? ☐ none ☐ abstinence ☐ oral

☐ condoms ☐ topical ☐ IUD/Implant ☐ natural family planning

When was your last menstrual period? _____

When was your last PAP smear/gynecological exam? _____

When was your last mammogram? _____

Do you check your breasts monthly for lumps or other abnormalities? ☐ Yes ☐ No

For MALES:

Do you check your testicles monthly for lumps or other abnormalities? ☐ Yes ☐ No

Are you currently experiencing any abnormal discharge from the penis? ☐ Yes ☐ No

When was your last prostate exam? _____

When was your last PSA (prostate surface antigen?) _____ ☐High ☐Normal ☐Unsure

Have you every had an elevated PSA? ☐ Yes ☐ No ☐ Unsure

Financial Policy and Agreement

Thank you for choosing us as your healthcare provider. We are committed to providing you with the best possible medical care. Please understand that payment of your bill is considered a part of your treatment. The following is provided to avoid any misunderstanding or disagreement concerning payment for services, tests, and supplies provided by our office.

Insurance

Our office participates with a variety of insurance plans. It is your responsibility to:

1. Bring your current insurance card to every visit and notify us of any changes in your insurance coverage.
2. **Be prepared to pay your co-pay, coinsurance and/or deductible at the time of service.** Payment may be made by cash, check, MasterCard, or Visa. All co-pays and deductible amounts owed are due at time of service. If your insurance applies any of your charge to your annual deductible or coinsurance, that portion is due and payable by you at the time of service. If you have elected to use our practice and our physicians out of your network of coverage please check with your insurance regarding benefit levels. Your employer or provider of insurance determines your benefit coverage by contracting with a particular insurance company. If you have questions regarding your coverage, please speak with your human resources representative or use the payer web address listed on your card. It is your responsibility to understand your benefit coverage.
3. We will submit a claim to your insurance company for you through our Billing Company, Advanced Reimbursement Solutions and Goldstar Medical Billing. Balances not paid per contract with your primary insurance company may be billed to your secondary insurance.
4. You understand that your insurance carrier can choose to assign benefits to Gulf Coast Healthcare or your insurance may make payment directly to you.
5. You understand and agree that you are financially responsible for all health care service charges that are paid to you directly by your insurance carrier.

Payment Details

We accept Cash, check, and most major credit cards. We have the capability to accept payments over the phone with your debit or credit card account information. We reserve the right to process your payment electronically based on the information you provide us.

Surgical and Laboratory Services

If you are having procedures at Gulf Coast Healthcare, the facility and surgical services are separate providers and will be billed separately from the office services provided to you. Laboratory services provided at our office are also provided by Gulf Coast Healthcare and will also be billed separately from the office services provided to you.

Non-covered services

If you are seeking a non-covered service, do not have insurance, or if you are covered by an insurance for which we are not a provider, we require that you be prepared to pay our fees at the time services are rendered. You may inquire with our staff about self-pay cash discounts for payment at the time of service. If temporary financial problems affect timely payment on your account you may set up a payment plan. Specific coverage issues should be directed to your insurance company's member services department (the number should be located on the back of your insurance card).

This office charges for all services that are significant and separately identifiable. Patients that are seen for physical exams and require treatments for illnesses or problems may be charged separately for each service when both are provided on the same day. This office can only code and file a claim for a patient's visit with a diagnosis that was encountered and documented in the medical record.

Collections

All balances billed are due upon receipt of a statement. Unpaid balances greater than 90 days are subject to our collection process.

Returned Checks

There is a $20.00 fee charged for all returned checks.

Small Balance Policy

If a credit or due balance exists on your account equal to $9.99 or less, and is more than 90 days old, the account will be automatically adjusted according to our small balance policy. If you are seen within the 90 day period, the small balance will either be credited to your account or requested at the time of service. Following the 90 day period, we will not issue any refunds or send statements for balances equal to $9.99 or less.

Appointment Cancelations/No-shows

If you cancel, miss or no-show for three (3) appointments you may be dismissed from the practice for not complying with the plan of care you and your physician have discussed.

High Deductible Health Plans (HSA, HRA, FSA participants)

Please inform us prior to your visit if you are a participant in a High Deductible Health Plan (HDHP), a Health Savings Account (HSA), a Health Reimbursement Arrangement (HRA) or a Flexible Spending Account (FSA). You must be prepared with-the plan information and pay the patient responsible portion from the HSA, H RA or FSA at the time of service

Minor Aged Patients

Adults accompanying minor patients (parent or guardian) will be required to complete a Release of Liability and Permission Form. The parent or guardian is responsible for payment of any financial balances for that minor not covered by insurance. For unaccompanied minors, treatment will be denied unless the proper paperwork is received, and the insurance card lists the minor's name.

I have read, understand and agree with this Financial Policy.

_____ _____

Printed Name (Patient or Guarantor) Date

_____ _____

Signature (Patient or Guarantor) Date

_____ _____

Office Staff Signature Date

Assignment of Benefits

Assignment of Medical Benefits and Payment Responsibility to Gulf Coast Healthcare, PLLC (hereinafter referred to as "Providers"). I, the undersigned patient ("Patient"), acknowledge that Providers reserve the right to use the services of Billing upon Providers' discretion for any part of the claims procedure. 1.**Legal Assignment of insurance Benefits:** In exchange for and in connection with any and all of the service(s) provided to me ("Services") by Providers, I hereby irrevocably assign to Providers all of my rights, benefits, privileges, protections, claims and any other interests of any kind whatsoever including, without limitation, direct payment to Providers for the Services, appeal rights, rights to fiduciary duties, rights to sue, rights to payment, rights to penalties or interest, rights to plan documents, and rights to information, notices and disclosures from any source, (collectively "Rights") that I had, have or may have in the future pursuant to or in connection with any insurance plan, health benefit plan, trust, fund or any other source of payment, insurance, indemnity or health or medical coverage of any kind (collectively "Health Coverage"), such that I am hereby transferring all and retaining none of these Rights under any Health Coverage to which I am now, previously, or may be entitled to in the future. Should this assignment be prohibited in part or in whole under any anti-assignment provision of my policy/plan, I instruct my applicable insurance plan, health benefit plan, trust, fund or any other source of payment, insurance, indemnity or health or medical coverage of any kind to please advise and disclose Providers in writing such anti-assignment provision within 30 days upon receipt of my assignment, otherwise this assignment should be reasonably expected to be effective and such anti-assignment is waived on any pending claims for benefits under the respective policies. I agree that, should the amount received be insufficient to cover the entire claim I be responsible for payment of any coinsurance and/or deductible that remains unpaid by my health insurance company, workman's compensation plan and/or auto accident insurance; I will be responsible to Providers for payment of the entire invoice. 2. **Denial of Claim:** I understand that Providers will make every effort to obtain payment for all health care services or products provided by Providers from my insurance company. I agree that I will be jointly and severally financially responsible for any portion of the Providers invoice that is not paid; I understand that I am responsible for any health insurance deductibles and co-payments; I hereby irrevocably assign the benefits payable for any services rendered by Providers to me and authorize Providers to submit a claim to any medical insurance company that I may have for payment to Providers. 3. **One Time Claim Submission:** I understand that Providers will make every effort to obtain payment for all services and or products provided by Providers. I understand that Providers will submit a clean claim one time. only and if the claim is not paid, in whole or in part, by my workman's compensation plan and/or auto accident insurance, Providers will look to me for payment of any Providers services and/or products supplied to me. I agree that I will be jointly and severally financially responsible for any portion of the claim, in whole and in part, that is not paid. 4. I certify that the information given by Patient to Providers in applying for payment to my workman's compensation plan and/or auto accident insurance or any other medical insurance that I may have, is correct. I agree that if assigned insurance benefits owed to Providers by me are paid to me, I shall immediately notify Provider of such, and immediately endorse benefits check to Providers. 5. **Appointment as Authorized Representative And Right to Sue**: I hereby designate Provider's designated billing company as my duly authorized representative in connection with all matters arising from or relating to Services, Rights and Health Coverage, such that billing completely and without reservation stands in my shoes and takes my place for all purposes, and is granted absolute power and legal authority to do, seek, claim, appeal or obtain anything that I would have been entitled to do, seek, _claim, appeal or obtain in my own capacity pursuant to or in connection with the Services, Rights or Health Coverage, in any legal, private, administrative, formal or informal process or forum whatsoever and without limitation, including any internal or external appeal, review, grievance or any other process, procedure or entitlement under any Health Coverage. 6. **Agreement to Cooperate:** In addition, I hereby agree to personally cooperate with, and take all steps necessary, required or reasonably requested by, any Health Coverage, to effectuate, perfect, confirm or validate my assignment and/or authorization of billing as my authorized representative, and I promise to assist and cooperate with Providers and billing as needed or reasonably requested by Providers or billing in connection with any action in any forum, whether legal, formal or informal, without limitation, commenced or maintained by Providers or billing in connection with the Services or relating to any Rights provided under the Health Coverage. I understand that, in the event I do not fulfill any of the above obligations, I will remain personally liable for payment for the Services to the furthest extent of the law. By signing below, I acknowledge my authorization of treatment and receipt of all documentation in accordance with my treatment.

_____ _____

Signature of Beneficiary/Participant/Parent/Legal Guardian Date

_____ _____

Printed Name of Beneficiary/Participant/Parent/Legal Guardian Date

Gulf Coast Healthcare

2825 East Nasa Parkway
Seabrook, TX, 77586
Phone: 281-532-3160
Fax: 281-532-3480

CONSENT FOR TREATMENT AND AUTHORIZATION TO PERFORM X-RAYS

Date: _____ Time: _____ AM / PM

I have been informed by Dr. _____ that diagnostic x-rays are advisable in my case so that a complete analysis can be made of my present musculoskeletal problem (or illness).

I authorize Dr. _____ to perform such radiographic examination necessary to diagnose and administer whatever treatment is deemed necessary to treat my present problem (or illness).

Signed: _____

Witness: _____

To the best of my knowledge, I am NOT pregnant and the above named doctor has my permission to x-ray for diagnostic interpretation.

Signed: _____